

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

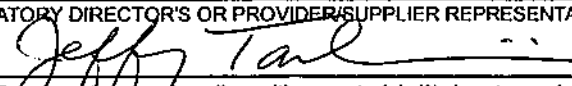
FORM APPROVED  
OMB NO. 0938-0391

45th 11/16/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/02/2013
---	---	--	---

NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, OAK RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 LABORATORY RD OAK RIDGE, TN 37831
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a clean and sanitary kitchen.</p> <p>The findings included:</p> <p>Observation with the Dietary Manager on September 30, 2013, at 9:10 a.m., in the kitchen revealed:</p> <ol style="list-style-type: none"> <li>1. A two inch pan, with liquid droplets on the inside of the pan stacked on top of other pans.</li> <li>2. A two inch and a four inch pan, stored with clean pots and pans, with a white crusty substance on the inside of each.</li> <li>3. A large commercial stand up mixer with a white sticky substance on the back shield and a black brown crusty substance on the arms that held the mixing bowl.</li> </ol> <p>Interview with the Dietary Manager on September 30, 2013, at 9:10 a.m., in the kitchen stated the white substance on the back shield "is from the whipped icing that was made yesterday. The back shields are supposed to be removed and cleaned after each use. It has not been cleaned."</p>	F 371	<p>This Plan of Correction is submitted as required under State and Federal Law and does not constitute an admis- sion on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <ol style="list-style-type: none"> <li>1. Dietary staff will ensure all pans/pots are cleaned, drained, and dried, on drying racks. The oven, deep fryer, and commercial stand up mixer will be cleaned after each use. The kitchen floor will be kept clear and dry. The immediate response was to check and reclean all items noted during survey.</li> <li>2. By ensuring the pots and pans are always cleaned, drained, and placed on drying racks, and each piece of equipment is cleaned after each use. This will correct any potential effects on all residents.</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10-15-13
---	------------------------	-----------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OCT 18 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2013
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, OAK RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 300 LABORATORY RD OAK RIDGE, TN 37831		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 1  Observation with the Dietary Manager on September 30, 2013, at 1:30 p.m., revealed: 1. Two ovens with black crusty substance on the bottom and sides on the interior of the oven. 2. The floor was wet, dirty and littered with paper and debris throughout the kitchen. 3. The large free standing floor deep fryer had a buildup of debris on the exterior top and sides.  Interview with the Dietary Manager on September 30, 2013, at 2:00 p.m., in the kitchen verified the above and confirmed the kitchen was not maintained in a clean and sanitary manner.	F 371	3. Staff was inserviced on safety, sanitation, proper cleaning, storage of pots, pans, ovens, deep fryer, commercial stand up mixer and the importance of keeping the kitchen floor clean and dry. Inservice completed on 10-15-13.  4. Dietitian and Dietary Manager will monitor the dietary staff for proper procedures in the cleaning and storage of pots and pans. Monitoring will also include proper cleaning of equipment and floors in the Dietary Department.	11-16-13	

15

10-15-13

OCT 18 2013